

Texas Vaccines for Children (TVFC) Program Vaccine Transfer Authorization Form

Guidance:

Texas Vaccines for Children (TVFC) providers are expected to maintain an adequate inventory of vaccine. Vaccine transfers are limited to: overstock of vaccine, short dated vaccine, withdrawal of a provider from the TVFC Program, non-routine replenishment of another clinic's inventory, or other (i.e. emergency, disaster or equipment failure). When a vaccine transfer occurs, the proper cold chain must be maintained. When a provider needs to conduct a transfer of vaccine from one clinic to another, permission must be granted from the designated DSHS Health Service Region (HSR) prior to the vaccine transfer.

Directions for use of this form:

The TVFC providers must complete the Vaccine Transfer Authorization Form (EC-67) for each vaccine transfer. Each vaccine that is going to be transferred must be listed on a separate row. Transfer requests must be signed by the DSHS HSR and returned to the clinic before a transfer can be conducted. The Vaccine Transfer Authorization Forms must be kept on file for a minimum of five years as required by the TVFC Program and made easily accessible.

Vaccine transfer in emergency situations (i.e. activation of the Emergency Vaccine Storage and Handling Plan):

In the event that a provider must activate their Emergency Vaccine Storage and Handling Plan, providers must transfer vaccines to the alternative storage location identified in the plan. The PIN/Customer ID for the alternative location should not be included on the Vaccine Transfer Authorization Form if the alternative location is not a TVFC provider. Providers must contact the DSHS HSR by telephone prior to faxing the Vaccine Transfer Authorization Form in the event of an emergency. If the DSHS HSR cannot be contacted, the provider may transfer vaccine to the alternative storage location and must notify the DSHS HSR as soon as possible.

Vaccine Transferring From:	Vaccine Transferring To:	Reason for Transferring Request: (Check the appropriate reason)
PIN/Customer ID:	PIN/Customer ID (if applicable):	1. Overstock of Vaccine <input type="checkbox"/> 2. Short Dated Vaccine <input type="checkbox"/> 3. Withdrawal from the TVFC Program <input type="checkbox"/> 4. Replenishing another clinic's inventory <input type="checkbox"/> 5. Other <input type="checkbox"/> _____
Facility Name:	Facility Name:	
Address:	Address:	
City/State/Zip:	City/State/Zip:	
Phone:	Phone:	
Fax:	Fax:	
Contact:	Contact:	
Email:	Email:	

I hereby certify, subject to penalty under the False Claims Act (31 U.S.C. § 3730) and other applicable Federal and state law, that VFC vaccine dose transfers reported on this form has been accurately reported and conducted in conformance with VFC provisions for such transfers and further certify that all VFC transfers will maintain the proper cold chain as outlined in the TVFC Provider Manual.

Provider Name: _____ Provider Signature¹: _____ Date: _____

DSHS HSR Representative Name: _____ DSHS HSR Signature: _____ Date: _____

¹ Provider or designee with authorization to act on behalf of the organization.



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